SENATE BILL No. 294

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Disproportionate share hospital providers. Requires disproportionate share payments to be distributed in a uniform and equitable manner. Makes changes to the distribution formulas for disproportionate share payments.

Effective: July 1, 2010.

Merritt

January 11, 2010, read first time and referred to Committee on Appropriations.

Introduced

Second Regular Session 116th General Assembly (2010)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2009 Regular and Special Sessions of the General Assembly.

SENATE BILL No. 294

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-15-1.1, AS AMENDED BY P.L.218-2007, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state

Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount not to exceed one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in an amount not to exceed each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. ~~A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer or certification of expenditures is made under subsection (d).~~

(d) Subject to subsection (e):

(1) an intergovernmental transfer may be made by or on behalf of the hospital; or

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under this section. The office shall use the intergovernmental transfer to fund payments made

under this section.

(e) A hospital that makes a certification of expenditures or makes or has an intergovernmental transfer made on the hospital's behalf under this section may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under subsection (b). The periods described in subsections (c) and (d) for the hospital or another entity to make an intergovernmental transfer or certification of expenditures are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition

precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 2. IC 12-15-15-1.3, AS AMENDED BY P.L.218-2007, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection ~~(g),~~ **(f),** from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount not to exceed one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount

calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 ~~described in subsection~~ ~~(c)~~ in an amount not to exceed each hospital's Medicaid shortfall as defined in subsection ~~(f).~~ **(e).**

~~(c) A hospital is not eligible for a payment described in this section unless:~~

~~(1) an intergovernmental transfer is made by the hospital or on behalf of the hospital; or~~

~~(2) the hospital or another entity certifies the hospital's expenditures as eligible for federal financial participation.~~

~~(d)~~ **(c)** Subject to subsection ~~(c).~~ **(d):**

(1) an intergovernmental transfer may be made by or on behalf of the hospital; or

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under subsection (b). The office shall use the intergovernmental transfer to fund payments made under this section.

~~(c)~~ **(d)** A hospital that makes a certification of expenditures or makes or has an intergovernmental transfer made on the hospital's behalf under this section may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under subsection (b). The ~~periods~~ **period** described in ~~subsections (c) and~~ **subsection** (d) for the hospital or other entity to make an intergovernmental transfer or certification of expenditures ~~are~~ **is** tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

~~(f)~~ **(e)** For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state

Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

~~(g)~~ **(f)** The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 3. IC 12-15-15-1.5, AS AMENDED BY P.L.3-2008, SECTION 92, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, and before July 1, 2007, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in

subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than sixty thousand (60,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state and paid Medicaid fee for service and managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals: ~~described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the nonfederal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals.~~

(i) on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient

days; or

(ii) other payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(c) As used in this subsection, "Medicaid supplemental payments" means Medicaid payments for hospitals that are in addition to Medicaid fee-for-service payments, Medicaid risk-based managed care payments, and Medicaid disproportionate share payments, and that are included in the Medicaid state plan, including Medicaid safety-net payments, and payments made under this section and sections 1.1, 1.3, 9, and 9.5 of this chapter. For a state fiscal year ending after June 30, 2007, in addition to the reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services reimbursable under this article and under the state Medicaid plan that were provided during the state fiscal year for all hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified in STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to all hospitals described in subsection (a). A calculation under this STEP excludes a payment made under the following:

(A) IC 12-15-16.

(B) IC 12-15-17.

(C) IC 12-15-19.

STEP THREE: The office shall calculate, under Medicare payment principles, a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) As used in this clause, "Medicaid inpatient days" are the hospital's in-state paid Medicaid fee for service and risk-based managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.

Subject to the availability of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent care trust fund under IC 12-15-20-2(8)(G) to serve as the nonfederal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis, based on the hospitals' Medicaid inpatient days or in accordance with another payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(B) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid as described in ~~clauses~~ **clause** (C) ~~and (D)~~ to a hospital that is described in subsection (a) and that is described as eligible under this clause. A hospital is eligible for a payment under clause (C) only if the hospital

~~(i)~~ has less than sixty thousand (60,000) Medicaid inpatient days annually.

~~(ii) was eligible for Medicaid disproportionate share hospital payments in the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001, and~~

~~(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004~~.

~~The payment amount under clause (C) for an eligible hospital is subject to the availability of the nonfederal share of the hospital's payment being provided by the hospital or on behalf of the hospital.~~

(C) For state fiscal years ending after June 30, 2007, ~~but before July 1, 2009, payments to eligible hospitals described in clause (B) shall be made as follows:~~

~~(i) The payment to an eligible hospital that merged two (2) hospitals under a single Medicaid provider number effective January 1, 2004, shall equal one hundred percent (100%) of the hospital's hospital-specific limit for the state fiscal year ending June 30, 2005, when the payment is combined with any Medicaid disproportionate share payment made under~~

~~IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.~~

~~(ii) The payment to an eligible hospital described in clause (B) other than a hospital described in item (i) shall equal one hundred percent (100%) of the hospital's hospital specific limit for the state fiscal year ending June 30, 2004, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.~~

~~(D)~~ For ~~state fiscal years beginning after June 30, 2009,~~ payments to an eligible hospital described in clause (B) shall be made in a **uniform and equitable** manner determined by the office.

~~(E)~~ **(D)** Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under ~~clause~~ **clauses** (A) and ~~clauses~~ (C), ~~or (D),~~ the remaining amount may be paid as described in clause ~~(F)~~ **(E)** to a hospital described in subsection (a) that is described as eligible under this clause. A hospital is eligible for a payment for a state fiscal year under clause ~~(F)~~ **(E)** if the hospital:

(i) is eligible to receive Medicaid disproportionate share payments for the state fiscal year for which the Medicaid disproportionate share payment is attributable under IC 12-15-19-2.1, for a state fiscal year ending after June 30, 2007; and

(ii) does not receive a payment under ~~clauses~~ **clause** (C) ~~or (D)~~ for the state fiscal year.

A payment to a hospital under this clause is subject to the availability of nonfederal matching funds.

~~(F)~~ **(E)** Payments to eligible hospitals described in clause ~~(E)~~ **(D)** shall be made:

(i) to best use federal matching funds available for hospitals that are eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(ii) by using a methodology that allocates available funding under this clause, Medicaid supplemental payments, and payments under IC 12-15-19-2.1, in a manner in which all hospitals eligible under clause ~~(E)~~ **(D)** receive payments in a manner that ~~takes into account the situation of eligible~~

~~hospitals that have historically qualified for Medicaid disproportionate share payments and~~ ensures that payments for eligible hospitals are equitable.

~~(G)~~ **(F)** If the Centers for Medicare and Medicaid Services does not approve the payment methodologies in clauses (A) through ~~(F),~~ **(E),** the office may implement alternative payment methodologies that are eligible for federal financial participation to implement a program consistent with the payments for hospitals described in clauses (A) through ~~(F).~~ **(E).**

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsections (b) or (c). The distribution to other hospitals under STEP FIVE of subsection (b) or (c) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) or (c) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 4. IC 12-15-16-1, AS AMENDED BY P.L.123-2008, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 1. (a) A provider that is an acute care hospital licensed under IC 16-21, a state mental health institution under IC 12-24-1-3, or a private psychiatric institution licensed under IC 12-25 is a disproportionate share provider if the provider meets either of the following conditions:

(1) The provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana. However, the Medicaid inpatient utilization rate of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient utilization rate.

(2) The provider's low income utilization rate exceeds twenty-five percent (25%).

(b) An acute care hospital licensed under **IC** 16-21 is a municipal disproportionate share provider if the hospital:

(1) has a Medicaid utilization rate greater than one percent (1%); and

(2) is established and operated under IC 16-22-2 or IC 16-23.

(c) A community mental health center:

(1) that is identified in IC 12-29-2-1;

(2) for which a county provides funds under:

(A) IC 12-29-1-7(b) before January 1, 2004; or

(B) IC 12-29-2-20(d) after December 31, 2003;

or from other county sources; and

(3) that provides inpatient services to Medicaid patients;

is a community mental health center disproportionate share provider if the community mental health center's Medicaid inpatient utilization rate is greater than one percent (1%).

(d) A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. However, this obstetric service requirement does not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

(e) The determination of a provider's status as a disproportionate share provider under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office.

(f) The office shall make disproportionate share payments to a hospital eligible under this section in a manner that is uniform and equitable to all hospitals, regardless of the year in which the hospital became eligible for a payment. The office shall apply to the United States Department of Health and Human Services to amend the state Medicaid plan to comply with this subsection.

SECTION 5. IC 12-15-19-2.1, AS AMENDED BY P.L.218-2007, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable; **and**

~~(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and~~

~~(3)~~ **(2)** ensure that payments for qualifying hospitals are **uniform and** equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

SECTION 6. IC 12-15-19-6, AS AMENDED BY P.L.218-2007, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2010]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits, including intergovernmental transfers of funds and certifications of expenditures, to permit the office to make the state's share of the required disproportionate share payments.

(b) For state fiscal years beginning after June 30, 2006, if:

(1) sufficient deposits have not been received; or

(2) the statewide Medicaid disproportionate share allocation is insufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' hospital-specific limits;

the office shall reduce disproportionate share payments made under IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance with the Medicaid state plan to eligible institutions using an equitable methodology consistent with subsection (c).

(c) For state fiscal years beginning after June 30, 2006, payments reduced under this section shall, in accordance with the Medicaid state plan, be made:

(1) to best utilize federal matching funds available for hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(2) by utilizing a methodology that allocates available funding under this subdivision, and Medicaid supplemental payments as defined in IC 12-15-15-1.5, in a manner that all hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1 receive payments using a methodology that

~~(A) takes into account the situation of the eligible hospitals that have historically qualified for Medicaid disproportionate share payments; and~~

~~(B)~~ ensures that payments for eligible hospitals are **uniform and** equitable.

(d) The percentage reduction shall be sufficient to ensure that payments do not exceed the statewide Medicaid disproportionate share allocation or the amounts that can be financed with:

(1) the amount transferred from the hospital care for the indigent trust fund;

(2) other intergovernmental transfers;

(3) certifications of public expenditures; or

(4) any other permissible sources of non-federal match.